Ennis Endocrinology Clinic

Robert Ennis, MD Jamie Ruiz, PA-C
2450 E Gala St, Ste 100
Meridian, ID 83642
www.ennisendo.com
info@ennisendo.com
Phone (208) 908-4541 Fax (208) 908-4542

Welcome to Ennis Endocrinology Clinic

We are truly honored to have you as a patient and value the opportunity to participate in your healthcare. Our mission is to employ a compassionate and patient-centered approach to the treatment of a variety of endocrine and metabolic disorders.

Please arrive 15-minutes prior to your scheduled appointment time with the following information:

- State/Government issued Photo ID
- Insurance card(s) *or* minimum down payment required
- The following new patient paperwork, completed prior
- Any relevant medical supplies/records you have

Location: We are located on the South side of Overland Rd, between Eagle Rd and Locust Grove, in Meridian. Parking and main entrance are located behind the back of the building.

Appointment times are in high demand, and highly valuable. In order to ensure a pleasant experience for each patient, we have implemented the following office policies.

Cancellation/No-Show Policy: If you are unable to make your appointment at the scheduled time, we ask that you give us at least 24-hour notice.
If we do not receive confirmation for your appointment, or if you arrive past your appointment time, we may need to reschedule your appointment

****Missed appointments / Same-day cancellations will incur a $25 fee*****

Laboratory: Our patients are able to get laboratory tests ordered by our providers in the comfort of our office, without a facility cost. Lab specimens are picked up daily, and results are directly integrated into your chart for review.

Prescription(s)/Refills: Please discuss all prescriptions/refills at your appointment. If you run out of medication before your appointment, please contact your pharmacy to have them fax us refill request, and allow 24-48 hours to process. If your pharmacy does not get a response from our office within 24-48 hours, please contact our office.

Billing: We accept most insurance plans with correct billing information. If your insurance requires a referral/authorization, it is patient responsibility to obtain an insurance referral/authorization prior to services rendered. Patients are responsible for non-covered amount for failure to obtain referral/authorization. *To inquire about how your services will be covered, please contact your insurance company.*

If you do not have insurance, *we ask for a minimum payment prior to the time of service.* We accept cash, check, and major debit/credit cards - Visa, MasterCard, Discover, and American Express. If you need to make payment arrangements, please contact our office *prior* to your appointment to discuss, or upon receipt of your statement.

By signing this form, you acknowledge you have read and understand our office policies.

_____ _____
Patient Name **DOB**

_____ _____
Signature of Patient/Legal Representative **Date**

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Patient Information

Name: _____ Date of Birth: _____/_____/_____

SSN: _____ Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address: _____ City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____ Ext. _____

Email: _____ (only for our office use)

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Disabled ☐ Other: _____

Employer: _____ Occupation: _____

Primary Care Physician: _____ Office/Group Name: _____

Location: _____ Phone Number: _____

Emergency Contact: _____ Phone: _____ Relation: _____

Primary Insurance Company: _____ Effective Date/Year: _____

Subscriber: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

Name: _____ Date of Birth: _____/_____/_____

Policy ID #: _____

Group Name/Employer: _____ Group ID: _____

Secondary Insurance Company: _____ Effective Date/Year: _____

Subscriber: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

Name: _____ Date of Birth: _____/_____/_____

Policy ID #: _____

Group Name/Employer: _____ Group ID: _____

Medical Information

Patient Name: _____

Current Medical Problems: _____

_____

Past Medical Problems: _____

_____

Surgical History: (Please list any operations you have had with approximate date/year)

_____

_____

Radiology/Lab Tests: (Please list any tests you have had in the past 12 months) (X-ray, Ultrasound, MRI, CT, Labs)

_____

_____

Allergies: _____

Prescription Medications:

Name	Dose (mcg, mg, mL)	Quantity/How Often	What do you take this medication for?

Other Medications: (Over the counter, vitamins, supplements, etc)

Name	Dose (mcg, mg, mL)	Quantity/How Often	What do you take this medication for?

Social History

Tobacco use: ☐ Never ☐ Current ☐ Previous If previous, when did you stop? _____

Alcohol: ☐ No ☐ Yes If yes, how many drinks on average per week? _____

Hobbies/Interests: _____

Family History: (Please list medical problems of your siblings, parents, and grandparents)

_____

Number of Children: _____

Patient Name: _____

Please indicate symptoms currently or recently:

Constitutional	yes	no
fever or chills	□	□
weight loss	□	□
weight gain	□	□
fatigue	□	□
night sweats	□	□
Eyes	yes	no
blurred vision	□	□
double vision	□	□
eye irritation/pain	□	□
wear glasses/contacts	□	□
Head and Neck	yes	no
neck swelling or lump	□	□
hoarseness	□	□
hearing loss	□	□
ringing ears	□	□
frequent nosebleeds	□	□
oral sore/dental problem	□	□
sinus problems	□	□
Heart	yes	no
chest pain/heaviness	□	□
muscle pain (walking)	□	□
irregular pulse	□	□
ankle swelling	□	□
rapid pulse	□	□
Lungs	yes	no
persistent cough	□	□
shortness of breath	□	□
wheezing	□	□
coughing up blood	□	□
pain on breathing	□	□
Blood	yes	no
easy bruising	□	□
excessive bleeding	□	□
persistent swollen gland	□	□

Gastrointestinal	yes	no
stomach pain	□	□
loss of appetite	□	□
difficulty swallowing	□	□
frequent constipation	□	□
frequent diarrhea	□	□
frequent heartburn	□	□
hemorrhoids	□	□
bloody bowel movement	□	□
frequent nausea/vomit	□	□
Kidney and Bladder	yes	no
testicular pain/lump (M)	□	□
penis sore/discharge (M)	□	□
erectile difficulty(M)	□	□
diff. passing urine (M)	□	□
painful intercourse (F)	□	□
very painful periods (F)	□	□
heavy periods (F)	□	□
irregular periods (F)	□	□
vaginal discharge (F)	□	□
painful urination	□	□
blood in urine	□	□
bladder/kidney infections	□	□
frequent urination	□	□
freq nighttime urination	□	□
loss of bladder control	□	□
Muscles/Joints/Bones	□	□
joint pain	□	□
joint stiffness/swelling	□	□
back pain	□	□
muscle pain	□	□
Allergies	yes	no
seas./constant allergies	□	□
hives	□	□
freq colds/infections	□	□

Skin/Breast	yes	no
acne	□	□
change in moles	□	□
excessive dry skin	□	□
itching	□	□
rashes	□	□
sores that won't heal	□	□
breast lump/tenderness	□	□
breast lump/discharge(F)	□	□
Neurological	yes	no
dizziness	□	□
fainting or spells	□	□
headache	□	□
memory problems	□	□
numbness	□	□
tremor/shaking hands	□	□
poor balance	□	□
weakness	□	□
Endocrine	yes	no
hair loss	□	□
excessive hair growth	□	□
heat or cold intolerance	□	□
hot flashes	□	□
excessive thirst	□	□
change in sex drive	□	□
excessive sweating	□	□
Emotional	yes	no
depression	□	□
nervousness	□	□
mood swings	□	□
sleep problems	□	□

Other current symptoms/complaints: _____

_____

_____

_____

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Acknowledgement of Privacy Notice

This notice is a summary of how your protected health information is used and disclosed and how you can obtain access to this information. Please see the front desk to review a full copy of our Privacy Practices.

Uses and Disclosures of Health Information

We use health information about your treatment to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

We may use or disclose identifiable health information about you without your authorization for several other reasons. Subject to certain requirements, we may give out health information without authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We provide information when otherwise required by law such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at anytime. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area and in each examination room. You can also request a copy of our notice at anytime. For more information about our privacy practices, contact the person listed below.

Your Rights

Although your health records are the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- Obtain a paper copy of the notice of privacy practices upon request
- Inspect and obtain a copy of your record as provided for in 45 CFR 164.524
- Amend your health record as provided in 45 CFR 164.528
- Obtain an accounting of disclosure of your health information as provided in 45 CFR 164.528
- Request communication of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information expect to the extent that action has already been taken

Below is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice. If you have any question or complaints, please contact our office.

Written Acknowledgement

I acknowledge that I have reviewed the Notice of Privacy Practices**,** which provides a description of information uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed.

_____ _____

Signature of Patient/Legal Representative **Date/Time**

_____ _____

Printed Name **DOB**

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Authorization to Disclose Protected Health Information (PHI)

This form is optional
If you would like to allow certain entities/individuals to have access to your protected health information (PHI)

Patient Name _____ **Date of Birth:** _____/_____/_____

I authorize the use and/or disclosure of Protected Health Information (*PHI*) as described below.

- Name of Organization(s) authorized to use, release or disclose the Protected Health Information:

  _____

- Person(s) authorized to receive Protected Health Information:

  Name: _____ Relation: _____

  Phone Number: _____

  Name: _____ Relation: _____

  Phone Number: _____

- I allow the disclosure of Protected Health Information to be left on my voicemail, in the event that I am not available:

  Phone Number: _____ Cell Home Work Other *(circle one)*

The information to be released may include information relating to the diagnosis and/or treatment of mental illness, alcohol/drug abuse, HIV test results, developmental disabilities, and genetic testing results **unless I give written instructions not to release such information.**

I have the right to cancel or revoke this authorization at any time. If I want to cancel this authorization, I must do so in writing and present it to the clinic. I understand that the cancellation (revocation) may not apply to information that has already been released.

I have a right to inspect and/or receive a copy of the Health Information to be released and that I may be charged for any copies of the records that I receive. Access to health information created or obtained may be temporarily suspended until the chart note/review has been completed. Once completed, I will again have access to my health information.

If no prior notice to revoke this authorization is received, this authorization will expire on (select one):

☐ _____ Year(s) ☐ _____ (enter specific date)

The information disclosed may be re-disclosed by the recipient and may no longer be protected by the Federal privacy rules.

If additional Health Information is required other than what has been identified above, another authorization form must be completed and signed.

_____ _____

Signature of Patient/Legal Representative **Date/Time**